County of Loudoun, VA
Request for Family *or* Medical Leave

Family and Medical Leave Act of 1993 – "FMLA"

To be completed by the employee. Copy to Benefits/Human Resources and Department Head.

Request for Family or Medical leave ***must be made at least 30 days prior to the date the requested leave is to begin.*** If the need for leave is ***unforeseeable***, the request should be submitted as soon as possible and practicable. Eligible employees must have been employed for ***12 months*** and have worked ***1,040 hours*** in the 12 months period prior to the start of the requested leave.

Employee's Name (Please print) _____ **Date of Request** _____

Address _____ **Phone Number or Extension** _____

Department Head's Name _____ **Department** _____

Reason for Request

☐ The birth of a child, or the placement of a child for adoption or foster care;

☐ Your own serious health condition that makes you unable to perform the essential functions for your job (including complications of pregnancy);

☐ A serious health condition affecting, your spouse ( ), child ( ), or parent ( ), for whom you are needed to provide care.

Beginning Date of Requested Leave: _____ Expected Date of Return: _____

For birth of a child, provide estimated date of delivery: _____

For adoption or foster care, provide estimated date of placement: _____

Is spouse an employee of Loudoun County Government: ☐ YES ☐ NO

If "yes", spouse's name & department: _____

For family member other than spouse, provide name and relationship: _____

_____

Total Number of Weeks Requested: _____

Total Number of Hours / Days ***(if intermittent only):*** _____

Please give specific details of your reason for requesting leave. If you are taking leave to care for a seriously ill family member, state the care you will provide and an estimate of the time period during which this care will be provided:

_____

_____

Intermittent or Reduced Schedule

If you are requesting leave on ***an intermittent or reduced schedule,*** please describe your needed leave below (i.e. doctor's appointments, physical therapy, etc.). Intermittent or reduced schedule leave may be taken due to your own serious health condition or to provide needed care for a spouse, child or parent with a serious health condition. When scheduling planned medical treatment, you must consult with your supervisor and make a "reasonable effort" not to unduly disrupt your department's operations. Leave should be scheduled to meet the needs of both employee and employer.

_____

_____

_____

This Request for Family or Medical Leave must be submitted to Human Resources / Benefits with a copy to the employee's Department Head. Appropriate supplemental forms and supporting documents should be submitted to Human Resources/Benefits.

If your request is *for your own serious health condition or the serious health condition of your spouse, child or parent,* you must submit a ***Certification of Health Care Provider*** (Form FMLA-102) from the treating physician ***within 15 days of the application for leave***.

If your request is for the ***birth of a child, or placement of a child with you for adoption or foster care,*** documentation of this event ***may*** be required.

Additional documentation may be required beyond the initial requested information.

I certify that the information given on this form is true. I understand that making false statements on this form is grounds for discipline up to and including termination of my employment. I further understand that a failure to return to work at the end of my approved leave period may be treated as a resignation unless an extension has been agreed upon and approved in writing by Loudoun County. I acknowledge that it is my responsibility to provide a copy of this form to my Department Head and submit the original to Human Resources / Benefits.

_____ _____

Employee's Signature **Date**

PAYROLL / FMLA

You must provide this section to your departmental payroll liaison in order to be paid according to your designation below.

You must designate the amount and types of your accrued leave to be used while on approved FMLA beginning _____.

	Hours / Day(s)	Week(s)	Pay Period(s)
Earned Sick Leave	_____	_____	_____
Earned Annual / Personal	_____	_____	_____
Leave Without Pay**	_____	_____	_____
*TOTAL	_____	_____	

*Total should equal the amount of leave requested. 1 week = 7 days (workweek is Thurs – Wed) FMLA = 12 weeks

**Refer to Notice Regarding Continued Health Insurance Coverage.

_____ _____

Employee's Signature Date